

a type of medical establishment that I would feel ashamed about.

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1 Strang J, Heathcote S, Watson P. Habit moderation in injecting drug addicts. *Health Trends* 1987;19:16-8.

SIR,—A vein of rich irony suffuses the leading article by Dr John Strang and colleagues. They define those who differ from them as polar opposites and then set themselves up as arbiters even though they are the protagonists who have created the polarisation. No responsible source has advocated maintenance for all, nor indeed do drug takers want that.¹ Where is there evidence that those who do prescribe maintenance do not also offer detoxification, withdrawal, or a host of other alternatives?

The authors' assertions about the "passionate preaching of zealots" also miss the point completely. Most drug users do not see themselves as in need of "treatment" any more than most tobacco users do (J H Willis, Royal College of Psychiatrists meeting, 1986) and the question is how to deal with this majority of drug users and their effects on society. Dr Strang and Professor Ghodse themselves inveigh against prohibition in the latest report of the Royal College of Psychiatrists,^{2,3} but if prohibition is ended, as they imply, how are drugs to be controlled?

The empirical picture of drug use demands flexible, pragmatic management. To remain empirical, rigorous evaluation is essential and in the Mersey region this has been carried out.⁴ Of a sample of 1019 patients, 9% receive maintenance prescriptions of injectable drugs and a further 25% receive syrup of methadone, subject to dissuasion, health care, advice, and counselling; 51% get no drugs at all. Further studies will judge the outcome of these policies. This is far from "all get maintenance." In contrast, the 55 drug users in Strang's quoted study continued breaking the law and risking their own and others' health using dangerously adulterated illicit drugs, from which only criminals profit. That some patients moderate their habits is the natural history of drug use, but even greater positive findings without the attendant risks can be achieved with maintenance—for example, of Dally's cases all but four reduced their dose and none increased their dose.⁴ The drug takers in the study by Gossop *et al.*, who agreed to admission for three weeks in a psychiatric unit, were a highly selected group and unrepresentative of drug takers as a whole. Furthermore, they were studied an average of 11 years after they started taking drugs. This suggests they were probably nearing the end of the "addictive set" and may have got better in spite of treatment not because of it. Even so, seven of the 57 failed to complete the inpatient programme, and only 12 of the 57 were drug free at six months and we do not know what has happened to these 12 since. This is better than the spontaneous remission rate of 5% per year but poor considering this was a highly motivated group, ready to give up.

Dr Strang and colleagues are right that general practitioners need to be more involved, but the *Guidelines of Good Clinical Practice* have had the opposite effect: some even feel they have been used as an instrument to arraign doctors for heterodox practice.^{6,7} The problem is that the guidelines do not address one of the most salient features of the natural history of addiction: that despite any intervention an addict remains addicted for several years. Maintenance has a place in managing such patients, but no guidance is given on this important tool in reducing harm.

Although maintenance prescribing is not "treat-

ment," it permits rehabilitation; anyway, the distinction between treatment and rehabilitation is arbitrary and can be counterproductive.⁸ Whatever policies are pursued evaluation helps establish their bases. Finally, your leader writers create another opposition: who decides treatment, doctor or patient? Why not doctor and patient?

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- 2 Edwards G, ed. *Drug scenes*. London: Royal College of Psychiatrists, 1987:213.
- 3 Fazey C. *Evaluation of the Liverpool Drug Dependency Clinic*. Liverpool: Mersey RHA, 1987.
- 4 Gage W. Prescribing schedules. Exhibit. GMC v Dally 1987.
- 5 Anonymous. Management of drug addicts. *Lancet* 1987;i:1068-9.
- 6 Marjot DH. Dally and the GMC. *Br Med J* 1987;294:573-4.
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Supplies of anti-Rh(D)

SIR,—The policy for administration of Rh(D) immunoglobulin for threatened miscarriage in rhesus negative women was clearly established in 1976 and endorsed in 1981. As far as we are aware, the only dissension in 1981 revolved round the suggestion and practicability of using the Kleihauer test in cases of threatened abortion.

Certainly full implementation of the agreed policy requires that if they have not already done so general practices need to develop ready access to Rh(D) immunoglobulin from their local blood banks, possibly even keeping a small stock themselves if they are to provide an effective domiciliary service. As Dr Deane Collinge says (28 November, p 1415), at its outset this may necessitate short term redistribution of the nation's supply.

Although strenuous efforts are being made to improve supplies of anti-D immunoglobulin, at present there is barely enough for standard prophylaxis as defined. Therefore, it would not be practical for general practices to hold large stocks because much anti-D would then be out of circulation.

None the less, the present supply difficulties should not detract from the longer term aim of providing immunoglobulin nationwide, for miscarriages as well as postnatally and, in time, even antenatally, to keep avoidable Rh(D) sensitisation to a minimum.

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SIR,—Until comparatively recently England and Wales were able to provide enough anti-Rh immunoglobulin for their own needs. The amount of plasma containing anti-Rh collected by the National Blood Transfusion Service has, however, been decreasing, and recently, when most of the anti-D stocks of plasma had to be discarded owing to contamination by plasma donations from a donor who developed a soft tissue sarcoma, the shortage was such that it became necessary to buy anti-Rh immunoglobulin from abroad. Dr J Dean Collinge referred to the effects of that shortage.

Experience at the North London Blood Transfusion Centre indicates that it would be easy to increase the procurement of plasma containing

anti-Rh in England and Wales to a self sufficient level. Before the recent shortage arose the north London centre was already providing about 20% of all the plasma containing anti-Rh sent to the Blood Products Laboratory. When it became clear that a national shortage was imminent procurement was increased.

Between December 1986 and May 1987, in screening almost 100 000 donors, 202 with anti-D were found. After explanation of the need for plasma containing anti-Rh about 150 of the subjects agreed to participate. After women of childbearing age had been rejected about 100 subjects were available for restimulation. They were asked to have a blood sample taken by their general practitioner so that the presence of anti-Rh(D) could be confirmed and the red cells tested for S, s, K, Kp^a, Fy^a, Fy^b, Jk^a, Jk^b, Le^a and Le^b.

Blood was received from 66 subjects; for 60 of these accredited donors whose red cells were compatible for the above antigens were available. After detailed explanations 42 of the 60 agreed to receive injections of Rh positive red cells and to undergo plasmapheresis subsequently.

Intravenous injections of up to 1 ml of red cells were given at intervals of not less than two weeks until the level of anti-D exceeded 100 IU/ml (20 µg/ml). Donations of plasma were then obtained every two to three weeks. The total amount of anti-D collected from October 1986 to September 1987 was 69.4×10^6 IU, whereas only 40×10^6 IU had been collected during 1985.

In October 1985 the anti-D working party of the National Blood Transfusion Service estimated the annual requirement of anti-Rh immunoglobulin for routine postnatal prophylaxis to be $80\,000 \times 500$ IU doses per year—that is, 40×10^6 IU. When the 250 IU doses required for immunoprophylaxis are taken into account the total annual requirement is estimated to be 54×10^6 IU. As the yield of anti-D immunoglobulin from plasma is only about 25%, the amount of plasma containing anti-Rh required annually is about 216×10^6 . The amount collected at our centre between October 1986 and September 1987 was thus about one third of the total requirement for England and Wales. Since the population from which we obtained the anti-Rh was 3.4 million and the total population of England and Wales is about 50 million, the amount of anti-Rh which could be obtained annually as plasma by measures similar to those we have adopted can be estimated to be 1×10^9 IU, or five times the total requirement for England and Wales when anti-Rh immunoglobulin is given only postnatally. This amount would in fact also be sufficient for routine antenatal immunoprophylaxis, assuming that two doses of 500 IU are given antenatally to all previously unimmunised Rh-negative women. In fact there would be more than enough anti-Rh immunoglobulin if the two doses given antenatally were reduced to 250 IU (50 µg) each.

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Brief intervention by general practitioners against smoking

SIR,—The study by Dr M A H Russell and others (14 November, p 1240) indicates that brief intervention by a general practitioner with smokers is no more effective than doctors' usual care and that more intensive intervention is required. This is